HEALTH COMMITTEE

OF THE

SUFFOLK COUNTY LEGISLATURE

Minutes

A regular meeting of the Health Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, 725 Veterans Memorial Highway, Smithtown, New York on Thursday, January 31, 2013 at 2:30 p.m.

Members Present:
Legislator William Spencer, Chair
Legislator Kate Browning, Vice-Chair
Legislator Robert Calarco, Member
Legislator Ricardo Montano, Member
Legislator John Kennedy, Member

Also in Attendance:
Legislator Kara Hahn, District No. 5
George Nolan, Counsel to the Legislature
Sara Simpson, Assistant Counsel to the Legislature
Renee Ortiz, Chief Deputy Clerk, Suffolk County Legislature
Alicia Howard, Legislative Aide, Clerk's Office
Lora Gellerstein, Aide to Legislator Spencer
Paul Perillie, Aide to Legislator Gregory
Ali Nazir, Aide to Legislator Kennedy
Bob Martinez, Aide to Legislator Montano
Michael Pitcher, Aide to Presiding Officer Lindsay
Craig Freas, Budget Review Office
Dr. James Tomarken, Commissioner, Suffolk County Department of Health
Art Flescher, Community Mental Hygiene, SC Department of Health
Nancy Hemendinger, Suffolk County Department of Health
Tom Vaughn, Assistant County Executive
Katie Horst, County Executive Assistant
Michael Stoltz, Executive Director, Clubhouse of Suffolk
Colleen Merlo, Executive Director, Mental Health Association
Mary Finnin
Other Interested Parties

Minutes Taken By:
Alison Mahoney, Court Stenographer

Minutes Transcribed By:

Kim Castiglione, Legislative Secretary

(*The meeting was called to order at 2:35 P.M.*)

(*The following testimony was taken by Alison Mahoney - Court Reporter & was transcribed by Kim Castiglione - Legislative Secretary*)

CHAIRMAN SPENCER:
This is the Health Committee meeting of the Suffolk County Legislature. It looks that we have a quorum. We are going to start the Health Committee. I'm expecting -- Legislator Montano is here and Legislator Kennedy will be here shortly.

LEG. MONTANO:
Mark me present.

MR. NAZIR:
He's in traffic.

CHAIRMAN SPENCER:
If we could stand and give a salute to the flag.

Salutation

If you could remain standing and if we could have a moment of silence for all those who have been victims of substance abuse and gun violence. We pray for those precious lives and their families.

Moment of Silence Observed

You may be seated. Good afternoon and welcome to the first meeting of 2013 of the Health Committee. And we have a -- a lot of returning Legislators, but I'm happy to welcome one of our senior Legislators, Legislator Montano, who will be joining us this year. But we do have returning Legislators Browning, Calarco and Kennedy and we had quite a year last year.

LEG. CALARCO:
This is my first run.

CHAIRMAN SPENCER:
Oh, it's your first run. I'm sorry, Legislator Calarco. I served with him on Government Ops, which is right before, but he's also new to the Health Committee. So welcome, Legislator Calarco. Thank you. And welcome back, Kate.

I thought I would begin the year with just a few thoughts and it will kind of dictate our agenda. I know last year was a difficult year because of dealing with the Health Department and all of its functions and then with the budget crisis and working through everything from staffing to our health care centers, to our nursing home. There was just a lot of difficult decisions that were made and we continued to face a lot of challenges.

(Legislator Kennedy entered the meeting)

In the interim what has occurred, then, and I'm just going to give a Chairman's comment and it will kind of guide our agenda, was the tragedy that occurred at Sandy Hook Elementary. And regardless of how you may feel in terms of gun violence with regards to gun control, we know that there's a problem, and we can all agree on that. And we may differ in terms of the solutions, and there's those that advocate for stronger gun regulation, there are those that say well, it begins with better

mental health, better services, but my opinion is that it's all of the above. We have to attack this problem globally, but there is a major issue when it comes to looking at mental health care services in this country, and a lot of times when we deal with mental health the injuries are internal, we can't see them. We can see someone that has a flesh wound and we know that it needs to be treated, but it's the unseen wounds that a lot of times fall by the wayside. So for me, serving on the Board of Health, I have asked them to join with me in terms of assessing where we stand here in Suffolk County with regards to our mental health services.

We need more out-patient treatment, we need more in-patient treatment, but more importantly, we can't forget about preventative services. And it all begins with really the emotional and well-being of our children, so it starts with our school educational programs, and hopefully if we head off this problem with preventative services it decreases some of the need for treatment services, but we do need all of the above. So our first presentation this year I have asked our Commissioner, Dr. Tomarken, to give us an update on mental health services in Suffolk County. I don't see him yet, though. Is he here? Oh, you'll be presenting?

MR. FLESCHER:
I'll be -- he's on his way but I'll be --

CHAIRMAN SPENCER:
He's on his way. Okay, excellent. But before we get to the presentation we'll give Dr. Tomarken a chance to arrive. We do have a couple of cards, and Michael Shultz (sic) is our first speaker. He will be talking about mental health, which is our topic today.

MR. STOLTZ:
Good morning.

CHAIRMAN SPENCER:
Good morning.

MR. STOLTZ:
Happy new year. Best wishes to the committee as you convene your work this year with some very difficult and challenging agendas in front of you. Pardon me, I struggle with speaking a little bit. I have some asthma kicking up, so I apologize.

I'm Mike Stoltz, the Executive Director of Clubhouse of Suffolk, a psychiatric rehabilitation, treatment and support agency. I'm also the Executive Director of Suffolk County United Veterans, which serves homeless veterans and currently runs some peer support work for veterans returning who have PTSD. And my agencies are also now aligned with the Mental Health Association in Suffolk, and the speaker right after me will be Colleen Merlo, who is the Executive Director of the Mental Health Association. We are now -- our three agencies are now merged and we'll tell you more about that in a moment.

We actually didn't know that Dr. Tomarken and Art Flescher were going to be speaking today and that you were going to, Doctor Spencer, were going to start out with some very eloquent and appreciated comments about the importance of our examining our mental health care systems.

So let me kick off and respond to your points by just kind of giving you a mantra for you to keep in mind as you examine mental health services, which is there is no health care without mental health care. And this is a national mantra.

I'm speaking sarcastically, thanks to the national attention to gun violence, as you presented, Dr. Spencer, mental health has never -- I will say in quite some time since the President's Commission on Mental Health under President Bush, has never received more kind of examination.

Unfortunately, most of it has castigated people with mental illness and miscast mental illness and mental health problems. These have generally been kind of we received all this attention through gun violence for all the wrong reasons because of all sorts of misperceptions about mental health and mental illness.

Let me couch this in a broader discussion for you as you set your agenda for the year, which is there is a tremendous amount going on in the world of mental health prior to Sandy Hook and now inspired further by Sandy Hook. Right now in Suffolk County and on Long Island and in New York State and across the country, all these things I ask and we ask to keep these on your radar screen as they are on ours.

On the first and kind of most simply forward, and Legislator Hahn, you've heard about this on your role on the Veterans Committee, which is a focus on military mental health, and what we have learned from our returning soldiers about the whole field of mental health prevention as you referenced, early intervention and care and peer support as we go on. As you may or may not know, Long Island has over 160,000 veterans. We are the largest County in the country that is home to veterans other than San Diego County, and we learn a tremendous amount. This is a County that suffered the end of last year I think it was seven or eight suicides of returning veterans that prompted County Executive Bellone to form a Military Suicide Task Force. And also a part of that experience has been the peer to peer -- the PFC Joseph Dwyer Veteran Peer-To-Peer Project that some of you heard about that our agency, Suffolk County United Vets, is partnering with the Veterans Service Agency and the County Division of Mental Health to be able to deliver that. So military mental health has to be on our agenda.

System change is already on all of our agendas thanks to the Governor's Medicaid Restructuring Task Force. We have concepts of health homes and behavioral health organizations entering into play, and I think the question for the County, these are State run initiatives that are getting handed off on a local level to providers like myself, and the questions become are they working for everybody? Is it making for affordable, accessible care for all our people? Is it really achieving the vision of fully integrated care?

Also on our radar has to be this whole issue of access to care, to early intervention, information referral, which is one of the hallmarks of the work of our Mental Health Association.

And last, but not least, is stigma. Many counties have funded -- Nassau County has funded stigma education in order -- recognizing the connection between stigma and misunderstanding about mental illness and people's reluctance to use mental health care systems.

CHAIRMAN SPENCER:
Mr. Stoltz, I love what you are saying. I have to kind of maintain a little order in the meeting. Could you wrap it up for me, please, and we'll get back to you.

MR. STOLTZ:
I'm wrapped. So we have a lot on our agenda. We look forward to working with you, and any questions and resources you need along the way myself and Ms. Merlo are happy to be of help. Thank you.

CHAIRMAN SPENCER:
We do have -- my colleagues did have some questions they would like to ask, and Legislator Hahn is first on my speakers list.

LEG. HAHN:
I just wanted to correct the record. I don't actually sit on the Vets Committee. I do often come and

listen, as I am doing now at the Health Committee, not a member of the committee but I'm listening, but thank you for what you are doing.

CHAIRMAN SPENCER:
Legislator Browning.

LEG. BROWNING:
Good morning, Mike -- or, afternoon. I'm sorry. I've been here all day.
MR. STOLTZ:
It's a long day.

LEG. BROWNING:
However, you know, I don't think you talked a lot about Project Hope, and I have to say Donna Napoli has been to my office and I have -- they have been -- they came in, they gave me the information, and I think they're probably sorry they gave me the information because we have sent them quite a few people. We have given them a lot of work to do. And I appreciate what they're doing.

But what I wanted to ask you, too, is when it comes to the mental health issue, I know this is something that we're very passionate about is when the Governor passed this gun bill, and they talk about mental health. How much money did he put in the budget --

(*Laughter*)

LEG. BROWNING:
-- to address the mental health issue?

MR. STOLTZ:
That would be a single digit of zero.

LEG. BROWNING:
So we're really going to be able to do something about it when they put no funding in the budget. And I know from the Federal level down they keep talking about it and I agree, you know, the mental health issue has to be addressed because when we look at those incidents that have occurred, it's always people with mental health problems. And it's really a shame that they're not putting the money in place and I don't know what we need to do to get them to wake up.

MR. STOLTZ:
Could I respond?

LEG. BROWNING:
Please, do.

MR. STOLTZ:
In the budget embedded in the gun violence legislation was a proposal to make Kendra's Law a permanent law. This is an out -- this is a law that provides for out-patient assisted commitment for people who have had any incidence of violence in their recent life. They can be mandated in there. So in making that permanent and not funding anything gives an opportunity to hand off to our court system more responsibility for we'll say governing and overseeing care, but not providing care.

LEG. BROWNING:
One last question. I know the other issue, and I do think there's a mental health component to this, and I know at the CJCC meetings we've had conversation about the young offenders who get sent Upstate, and now they're no longer going to be -- they're closing the facilities Upstate and they're all

going to be so-called taken care of here on Long Island. And I do believe that there's, you know, there is a mental health component to some of these young offenders. And I look at Pilgrim State and Kings Park and when they closed they really made no plan for what they were going to do. That's my opinion. But, you know, are you looking at this issue with the young offenders?

MR. STOLTZ:
I was a part of the Criminal Justice Task Force as well for a while. I've had to drop out, although my agency takes referrals by way of that. So forensic mental health has absolutely been on the radar screen, and I'd defer to Art Flescher to probably be able to tell you more about that when he makes his presentation.

LEG. BROWNING:
Well, thank you. But again, it's another concern and I'm concerned about the lack of funding for that issue, too.

MR. STOLTZ:
Absolutely. Thank you.

CHAIRMAN SPENCER:
Legislator Kennedy.

LEG. KENNEDY:
Yes, my comments basically are first of all, to thank Mike for being here. Not only is Mike my constituent, but a personal friend of mine and actually someone who I worked with probably more than 30 years ago when I was then in the New York State Department of Mental Health as a vocational rehab counselor. He has a long and distinguished career working with the mentally impaired populations. I commend him for promoting the collaboration that we so often talk about here of agencies. He's actually stepped forward and is actually walking the talk and bringing together agencies that can ultimately deliver service while benefitting from each other's back office synergies and helping to stretch our municipal or public dollars further in doing so.

The other piece that comes to mind with Legislator Browning's comments and the Governor's legislation, it was only seven months ago that we were -- the layoff of the Social Worker that works with the court regarding Kendra's Law. So if we are expanding and actually looking at a greater population, not only do we have to look at the State dollars to assist us with that, we need to be mindful here of what the impact is. All the legislation in the world that comes out of Albany is wonderful, but the rubber hits the road down here. This is where we wind up implementing it and delivering it. So we'll be looking to you for guidance and help with that.

MR. STOLTZ:
If I can respond to a couple of things? One, I'm not a huge advocate of Kendra's Law, which is a whole nother (sic) discussion.

LEG. KENNEDY:
Okay.

MR. STOLTZ:
Number two, just responding to your points about mergers of non-profits, and this is a conversation I've had with Legislator Cilmi, who's had and withdrew a couple of pieces about non-profit oversight and governance. In our situation both Executive Directors, John Lynch of Suffolk County United Veterans and Colleen Merlo of the Mental Health Association, approached Clubhouse of Suffolk, so I certainly cannot take credit for their courage and wisdom to be able to look at consolidation.

LEG. KENNEDY:
You run a good shop, you know, you're sought out.

MR. STOLTZ:
However, let me also just say, you know, you referenced about savings and consolidations of dollars. There is a myth about mergers of non-profits. These cost money, these take time and these have to be extremely well thought out, and when you have seen one merger, you have seen one merger, and the benefits of them are not generally about savings.

LEG. KENNEDY:
It has to be the right fit, there's no doubt about it. As a matter of fact, each of you comes from a unique perspective and I agree with you, we can't just impose some kind of a cookie cutter mandate on the not-for-profit and service sector. No doubt about it. In this case, the Mental Health Association I know from my days back with Mary Reilly and folks like that, and there does to me seem to be some natural synergies --

MR. STOLTZ:
Absolutely.

LEG. KENNEDY:
-- between your direct service delivery and the population they advocate for. And certainly with John, he's always done great work on the behalf of Veterans. And the veterans today that are coming back, you see it better than anybody, even though the Veterans Administration made efforts to expand the PTSD evaluation and things for our Vietnam Vets and even, you know, Desert Storm, today's vets returning are presenting challenges, Doctor, you know this, the TBI trauma is difficult to identify, difficult to ferret out, but extremely pervasive and undermining and needing to be worked with. So we're glad you're there. Thank you.

MR. STOLTZ:
Thank you.

CHAIRMAN SPENCER:
Thank you.

MR. STOLTZ:
Thank you for your time.

CHAIRMAN SPENCER:
Our next card is from Colleen Merlo, also addressing mental health.

MS. MERLO:
Thank you. My name is Colleen Merlo. I am the Executive Director of the Mental Health Association in Suffolk County. The Mental Health Association in Suffolk County is dedicated to helping Suffolk County residents live mentally healthier lives through education, prevention and advocacy. We offer the following recommendations as well as our assistance to move our County forward towards greater understanding of mental health and the inclusion of thousands of our fellow citizens who are experiencing mental illness and addiction challenges. I want to thank you, Legislator Spencer, for your very wise words in the beginning, and I thank you for the opportunity to talk with you today.

There is no health without mental health. This is true of individuals, communities and our nation. It is well understood that mental health promotion initiatives foster healthier individuals and communities, and that people recover from even the most serious mental health and addiction challenges when they have access to the needed treatment and supports. But mental health and substance use systems have chronically been underfunded. They are overinvested in crisis services, leaving scant dollars for early access to treatment to avoid crisis, or for effective evidence based and promising practices for prevention.

As we have this conversation, first we must vigorously debunk the widely accepted but incorrect idea that people with mental illness are more violent than the general population. They are not. In fact, they are much more likely to be victims of crime than to be perpetrators of crime. Ninety-five percent of violent crimes are committed by people who do not have mental illness, and we must promote understanding that violence can cause mental health problems. Witnessing violence in our communities and homes is traumatic. Experiencing trauma can lead to a myriad of mental health, substance use and emotional and relational issues. The current conversation in this County and State must be focused away from fearing and controlling people with mental illnesses. It must be shifted to the importance of preventing -- prevention and preventing interpersonal violence and its negative mental effects, and to promoting access to treatment and supports when people need them.

We must engage in serious planning for adequate community based mental health system, one with different pathways for people to access appropriate treatment, and support people who come with us fear -- with fear and shame and marginalization and who feel discriminated against. The path to healthier and safer communities is a recovery focused array of community based mental health and addiction services that promote hope, recovery and community inclusion.

One of the services that the Mental Health Association provides is our information and referral service, and we receive over 6,000 calls every year for people looking for services. And then in addition we also screen calls through the internet. What people say is oftentimes this is the first call that they're making in order to access treatment. More often people are saying you know what, you're my last call because I've called so many other places and I haven't really gotten what I needed. We need to invest more in helping people know that there are treatment services available. We need to get into the schools and promote that prevention really does work. We know that early intervention is the key to better outcomes for people, but oftentimes people don't know where to call. Our information and referral line could use additional funding because we really want to promote it as this is the number to call when you're having mental health difficulty. We can help you access care in your community.

We must invest in individuals, families and our communities. We must focus on prevention, provide mental illness and addiction prevention and early intervention strategies to school to promote resiliency. Such programs would promote the use of evidence based practices in school and community settings for youth. We must also provide and insure that local schools and health systems are ending discrimination and marginalization through compliance with the ADA laws. We must promote hope by including individuals and families who have mental health and addiction challenges in the work of the State and local mental health reform initiatives.

We have to acknowledge the fact that one in five Americans are affected by mental health challenges, and embrace the millions of people who are our family members and friends. These are not people to be feared. These are people we're sitting next to every single day, and we need to really promote that better to help end the stigma, because the stigma is one of the reasons that people don't seek out treatment. That, and the third leading reason that people don't seek out treatment is because they don't know where to go, and that's where I'm asking for some help, to help promote the fact that there are resources in our County.

I know my time is up, so I will end there, but thank you. This is the beginning of a conversation.

CHAIRMAN SPENCER:
Thank you. I appreciate that, your remarks and that you were definitely on the same page, so thank you.

MS. MERLO:
Thank you.

CHAIRMAN SPENCER:
That's the last card that I have. Is there anyone else wishing to be heard? With that, I'm going to move on to our presentation, and along that same vein we have our Commissioner, Dr. Tomarken. I'll ask if he would come forward and have a seat at the table. Specifically, I've asked if he would give us a presentation with regards to the current mental health services that are available in Suffolk County and that he would take five or ten minutes to just update us, and we'll answer any questions that my colleagues may have. Thank you, Commissioner.

COMMISSIONER TOMARKEN:
Thank you, and good afternoon. I think the best way to handle this is to have our Director of Community Mental Hygiene, Art Flescher, make the presentation and I'm here for questions as well.

MR. FLESCHER:
Thank you very much. Dr. Spencer, thank you for inviting us. The rest of the committee, I appreciate this opportunity to provide a briefing on the mental health system in Suffolk. It's a network of providers that we're extremely proud of. You just heard from two of them, and there are many others and I encourage all of you to get to know the providers in your communities, because they really do an amazing job and we have a great partnership in this County.

To put it in perspective for a moment, and some of you are well aware of the storied history in Suffolk County. At one time we had over 30,000 people hospitalized in three large State psychiatric facilities. That represented fully one-third of the people that were hospitalized statewide, and pretty much this was a State operated system almost in its entirety, and a very big industry. Over the last several decades, as we know, there have been waves of deinstitutionalization, and to give you an idea, right now there is one State facility left, Pilgrim Psychiatric Center, and there's less than 400 people in that facility.

During that time there's been a massive shift, obviously, towards community based services, and with that there have been tremendous improvements in the care of individuals with mental illness. We have moved from an historic medical model in which pretty much it was hierarchical, in which it was doctor, patient with very little person centered work, to one that is far more person centered and one that focuses on rehabilitation and recovery.

There are countless numbers of lives in all of our communities of people who are recovering from mental illness every day. It's very important that we all accept that and realize that, because I think the issue of stigma remains such a powerful one in terms of people seeking help, in terms of people telling others about the need for help. One of the things that a prior Commissioner with the Office of Mental Health had said that still resonates with me was that the best way to combat stigma is to get to know somebody with serious mental illness, because that really brings home the fact that people do recover. And, yes, in many respects, particularly the serious illnesses, tend to be chronic and tend to have relapses. They can be few and far between with proper care.

As mentioned by a prior speaker, we're still talking about a problem that one in five people in our society has. So the issue of mental illness is wide ranging, and when you add in all the friends and family members that are affected by it, there's not too many of us that aren't in one way or another. And yet, as I mentioned, it's very hard for people to seek that help or to talk about it because all the while they're wondering why is this happening to me? Why can't I just get stronger? Why can't I pull myself up by the proverbial bootstraps and just simply get better? After all, it's all in my mind, right? And of course we now know very much how much of this is a brain disease and how treatable it is, but getting people to seek care is a huge problem. And obviously Newtown caused us all to

pause in ways that I think hasn't hit us in quite the same fashion, primarily because young children were involved. And the question of well, is this mental illness, is this related to gun control, as Dr. Spencer mentioned very, very well, it's a multiple issue. But certainly I'd like to address for a moment the issues, the ways we're approaching it in Suffolk County in terms of this concern about serious mental illness in young people, because I think it's paramount.

First of all, about half of the young people that develop serious mental illness evidence symptoms by the age of 14; fully 75% will evidence systems by 24. And what makes this as a chronic illness so tragic for so many people and so debilitating, is the fact that without care they will have multiple events, multiple psychotic events, that each one causes cognitive damage. It makes it more difficult to recover. Recovery happens, but the more you can prevent that initial psychotic break the better you are.

One of things we've embarked upon in the Division of Community Mental Hygiene is we made contact with Columbia University and we've offered in any way possible to get involved in an initiate they started look at called the First Psychotic Episode Initiative, in terms of coming up with state-of-the-art treatment so that we can engage young people that evidence early stages of Schizophrenia or serious bipolar disorder, because although treatment is not as sufficient as we would like in terms of capacity, the other issue is treatment practitioners have a difficult time engaging many young people. Part of the reason is because as a young person there's a total element of denial that they could possibly be that ill. Medications, for all their good, also have a down side, which is weight gain, in some cases dysphoria rather than euphoria, and there's a struggle that people go through that makes it very difficult for them to stay on medication, particularly when young. Only when they're older and they've had multiple hospitalizations do they sometimes say I accept that this is what I need to do. We need to get better at finding ways to engage those young people and treating them more quickly and having less barriers.

As Colleen Merlo had said, one of the things we would like to do is also address access to care. Access to care is one of those things you'll hear differing views on. You'll hear on the one hand people call over and over again to different places, and then in other ways you'll hear many of our agencies, for example, you may not know this, have what are called walk in assessments at this point. They have a couple of days a week where you can just walk in at any point and begin your treatment. So the access to care in those clinics is quite available, yet there's a disconnect in terms of people's knowledge.

It's difficult to coordinate all of that information, so I'm hopeful about working with the Mental Health Association in terms of making that number as they ask to be a central number that people can reach out to. And I think we should look at some ways that we can publicize that and make it so that maybe through a variety of efforts we can simply let the public know there's at least one place you can call and you will have assistance in navigating, because it is not easy and the system is changing markedly, as mentioned, with managed care and all the other things that are going on. Navigating can be difficult, but imagine how powerful it is to finally develop the courage to make that first call only to discover that my insurance doesn't take this -- this clinic won't take my insurance or they don't have capacity, I have to wait four or five weeks, I need it now.

We have a good system in Suffolk County in my many regards. We have, for example, part of the role of the Director of Community Services is we have the ability when people are in imminent danger to self or others, through our designee system we can arrange for transport to Stony Brook CPEP. And CPEP, as you know, is a state-of-the-art facility. It's been totally redone, it's beautiful, and really represents something that we should all be proud of.

The Mobile Crisis Team is something that we invested quite a bit of resources in, and what happens is when somebody calls my office and they express concerns about somebody, the first thing I do is have the mobile team go out. The mobile team will assess. They have the ability to authorize

transport, we put them through a special training for that, or they can refer to out-patient treatment and that person will get priority care. That is something we can really be proud of as an intervention tool that we have. We have a variety of ways of addressing these things.

The other point I wanted to make in public education for young people is that there is a program called Mental Health First Aid, and one of the things I've talked to the Mental Health Association about is getting people trained so we can use that program. Basically it's geared towards training all of us about the signs of mental illness, the resources available, because who knows first that somebody's having problems? Friends and family. And so part of this multi-pronged approach, increasing accessibility, using state-of-the-art engagement techniques and public education I think represents a real promise.

In cases where there's chronic relapse, unwillingness to engage in care, and things such as that, we still have the mechanism of Kendra's Law, assisted out-patient treatment, wherein Suffolk County we currently have about 150 people that are being monitored through Kendra's Law, and we've had about 600 since the program began, 600 unique individuals, since 1999. It's a wonderful, wonderful effort and represents a tremendous collaboration. The idea is you don't want to reach that point, because you need to go before a judge. It is somewhat coercive. The person certainly oftentimes feels very resentful of the entire process, but for some folks that refuse to engage in care and have the potential, have evidence clear potential for violence or other self-destructive behavior, and by the way, the likelihood is far greater that those violent efforts will be geared towards self than others. Very sadly we see this often. And so Kendra's Law is there to assist those folks.

And what's really nice about it is each week we have what's called a Clinical Review Panel. They meet every Thursday in our office. They discuss each one of those 150 people, not all of them at great length, but they get progress reports and it represents an excellent model that we would like to do for some other people before they need to go before a judge. I have always said it would be far better to be able to do this through a non-civil court kind of situation, but rather to bring somebody forward and say, "This is not working for you. Why don't you agree to this?" And we try that, but sometimes it doesn't work, but we would like to expand those efforts.

In closing, I would just like to say that the system is changing markedly. Mental health services as we have known it throughout my career is going to be quite a bit different in the future. Within two years we'll have a fully Managed Care system, okay, in which a large, managed care entity, whoever that may be, will have a lot of say in what care people provide and what care people receive. That's going to change things markedly for local government. I dare say that the role of local government is probably more important than ever, because there are all these people that will fall between the cracks, all these people that are brought to our attention every day that we still need to be as strong and vibrant as we can be to hold the system accountable, the network of providers, as well as advocate if the managed care entities aren't fulfilling their end of the bargain.

But I just want to communicate that it is a very receptive, caring system and one that we're exceedingly proud of. We have work to do, there's not enough of it. We would certainly like people to be able to say, "You know what? When I need care, I know where to get it." But we certainly need to get commercial insurance on board. There's a lot of other things given more time we could discuss, but I think at that point I'll stop and any questions, I would be happy to answer.

CHAIRMAN SPENCER:
Any of my colleagues? I have a couple of questions. Legislator Kennedy.

LEG. KENNEDY:
Art, the only thing that I guess I would ask you, and you don't have to expound upon it now. You -- and first of all, I'm eager to hear how you see the system going forward, but one of the components in mental health care, as you know, and there's a whole debate, even still today, about substance

abuse and the role we play now and the role we're going to play going forward into the future, and if you see that subset changing as you do the broader delivery of mental health care by us and the role we play, you know, in the County.

MR. FLESCHER:
Well, certainly one of the things that we address all the time, first of all, is the issue of co-occurring disorders. We have a program in our Farmingville clinic called the Dual Recovery Program that is tremendous in terms of offering intensive care for people that have both substance abuse and mental health problems. And the issue of co-occurring disorders is extremely, extremely common, because keep in mind, years ago when people were in institutions they didn't have access to street drugs or alcohol to any great degree. Now as people live in the community, they use substances for the same reason everybody else does, because they work. They change the way think, feel and act, so people are certainly attracted to that, but if you have serious mental illness that really causes an exacerbation of your problem. So we really work hard at addressing that. We need more MICA housing, mentally ill chemical abusers, we need more mentally ill chemical abuser services in general.

The other part of it is, I don't know if you're alluding to the issue of dealing with chronic opiate addiction, but that's certainly another issue as to what our future is going to be with methadone services and some of the other things. We are certainly looking at all that and hoping that, you know, obviously we're an integrated division. As part of the Health Department we are responsible for the oversight of the developmental disabilities, mental illness and chemical dependencies, and we will have a role in all three going forward, regardless of how that is set up completely is unclear to me.

LEG. KENNEDY:
And through the Chair, I don't expect you to be able to deliver crystal answers today, but yes, you really are hitting on it, both facets, both components and in particular the opiates addiction. I do want to -- we've had an ongoing and continuing discussion about suboxone. By no way, shape or form am I a physician or for that matter a pharmacist or a chemist. I don't know if that's the medication that's the preferred alternative or if by now there's yet another one that's emerging, but in lying with -- look, just like I worked up in a mental institution 30 years ago, that's closed and it's being torn down. The -- why can't I think of it now. What do we give for -- methadone.

MR. FLESCHER:
Methadone.

LEG. KENNEDY:
Right. That's what was the prevalent and drug of choice in the 60s and 70s. There's some thinking that now perhaps maybe there's a different best practice for prescribing what way to go when we treat.

MR. FLESCHER:
As you say, that's probably a separate topic, but I would submit to you, and I will forward to you an article that has me concerned about suboxone diversion and suboxone abuse among people that are novice opiate abusers because it does create some effects that are more moderate than some of the other opiates, but it's kind of, you know, it's kind of an introduction to opiates for a lot of young people, so there's concerns. There's a lot of discussion as to the state-of-the-art with the field, yes.

LEG. KENNEDY:
No doubt about it. But on the flip side, and last comment, Doctor, a tip of the hat and Legislator Hahn and I will both say to you in our wildest dreams we never thought the Narcan Program was going to work the way it has. I know your department, Doctor, as a matter of fact, has been the lead on the pilot, working in conjunction with the Police Department. I personally feel it's one of the

best things that I have been involved with since I have been here in the Legislature, because it's 43 or 44 less funerals that have gone on in less than a year's period of time, so thank you. And please, please, you know, continue to promote that. I hear that the pilot is being converted to a fully accepted protocol very shortly and I'm hopeful that's the case.

COMMISSIONER TOMARKEN:
I just wanted to make a comment. The division between mental health and substance abuse is very artificial. It's estimated that 70 to 80% of substance abuse patients have mental illness, so that's been done for organizational, financial and convenience reasons, not because that's the best way to treat people.

LEG. KENNEDY:
Sure. Sure. Thank you. Thank you, Doctor.

CHAIRMAN SPENCER:
Thank you. Legislator Hahn.

LEG. HAHN:
And I want to echo what John said about the Narcan. I have a bill on the table that has been tabled because we can't quite work out exactly how we want it to happen, but those 39, 44, you know, lives that we've saved and those that we will as we move forward with Narcan, you know, I feel we have a responsibility to help work to get them into treatment. I've been talking to Dr. Coyne and our latest conversations are going to have me talking to you guys soon, so I hope we can follow-up.

But I also want to ask -- and Art, you know, you and I have had some discussions on this and I want to continue. I want to bring Dr. Tomarken in on the screening and brief intervention for treatment, SBIRT screening tool, and how we can, you know, move forward trying to screen and catch things maybe early or find ways to get people into treatment in our health clinics, and maybe some other ways. And so I want to -- I do want to bring Dr. Tomarken in on those discussions and hope that we can get it happening at our clinics.

MR. FLESCHER:
We fully agree, Legislator Hahn. As you know, we're going to be piloting that in our Brentwood Health Center. We have a training schedule for March and we're looking forward to that, and the plan is to proceed with the Coram Health Center through Hudson River and to begin to do that, because it's wonderful. It's a way of getting reimbursed for something that should be done anyway, and it's a way of screening people and hopefully providing access to care.

COMMISSIONER TOMARKEN:
The other thing that it does is it helps to destigmatize mental illness.

LEG. HAHN:
And I think that we need to, you know, establish a County-wide protocol that regardless of what division, you know, we're really implementing this and get it to work for the whole system. So, you know, I really look forward to additional conversations on that, and thank you for those thus far. Thank you.

CHAIRMAN SPENCER:
Thank you, Art, for your presentation, and I'll make a couple of remarks myself. My goal is to have an understanding of the services that we currently provide and also looking at providing resources for areas that were lacking. There's a couple of quick follow-up questions. I'm an officer in the Suffolk County Medical Society. I understand that there is -- there are some State legislations that are being considered with regards to referrals for mental health treatment in situations where health care providers may be dealing with someone that may be decompensating and placing a

requirement and notification requirement to County health services. And there was some concern with regards to providers who have had relationships for -- with patients that are longstanding, those patients have developed a trust where if they are decompensating they may seek out treatment but -- and then the judgment of that professional, that if they feel that they have the situation under control, but if these laws are passed there's a concern that those providers will be forced to notify County mental health services. And the concern is that that -- if that -- it becomes known throughout the community, that this may drive some people away from seeking treatment. Are you aware of this particular issue and do have a thought about that?

MR. FLESCHER:
Actually, I appreciate you bringing that up, because that ties in with the Safe Act, New York Safe Act, in terms of basically what's happened is the Safe Act proposes that four disciplines, professional disciplines, M.D.'s, nurses, psychologists and licensed certified social workers are to report anybody they're treating who is viewed as being likely to be dangerous, and the report is required to go through the Director of Community Services, my office, and we're in turn to put that report -- we're supposed to vet it in terms of whether it's appropriate and then make a decision as to whether, in fact, it should be reported to DCJS on the State level in terms of somebody that may have weapons or whatever that might be. The concern obviously is for a large County such as this, this is truly an unfunded mandate and we have already received numerous calls saying how do I start reporting people. And there's a lot of concern about, yes, pushing people away from care, creating an onerous situation for local government and in general wondering what the reality is, because we don't have the manpower to be able to truly investigate these cases. Like I said, I can send out the mobile team for certain cases, but by and large most of them we're going to err on the side of caution and we're going to report that, because we're not going to make the decision not to, but I don't know what the point is to have local government having that role.

So one of the things we've talked about with the Trade Association Conference of Mental Hygiene Directors is that perhaps it should be through a central registry on a State level, and then cases that are appropriate to be brought down to the local level for us to be involved in partnership to look at would make a lot more sense. But you're correct in saying that people are concerned about rapport issues, people not seeking care, being reluctant to because of concerns of how they will respond to that.

I should mention at the same time that there is something in the State budget which also is disconcerting, and it's called -- removing what's called prescriber prevail for anti-psychotic medications. So on the one hand we'll be driving more people into care or potentially, but prescriber prevail basically means the doctor has the final say with which medication is used. And as you know, with anti-psychotic medications there's a host of them. There's an older generation and there's a newer generation called atypicals. The older generation are all generic, the newer generation are more expensive, and it's always been -- it's been a true rule out method as to what works with certain individuals. There's a lot of concern -- that will be a nine million dollar State savings to remove that. But people are concerned that in the midst of the current concerns regarding the mental health care in the country should we be taking away that. So there's a lot of different things, and yes, we pay very close attention to State legislation and various trends through our partner State agencies because we need to be chiming in on many of these things.

CHAIRMAN SPENCER:
Would you keep us informed as to the status of this? It will be very important for us in terms of weighing in on this issue, and your thoughts dealing with it every day are extremely valuable. I appreciate your presentation. It was exactly what I was looking for to start to understand this issue. Obviously there's a lot of things that we can discuss, but you have kind of given us an update and we'll kind of continue this conversation. So, thank you. Art, thank you so much.

MR. FLESCHER:

Thank you. If I can just mention one more quick thing. In our health centers, just so you know, we have depression screening in all of the health centers using an evidenced based initiative that we as a collaboration between the Patient Care Division and Mental Health several years ago, and that's going quite well. So that kind of model is one that is a really good model to look at.

CHAIRMAN SPENCER:
Legislator Calarco has a question for the Commissioner.

LEG. CALARCO:
Dr. Tomarken, I have just a quick question for you, and it's not on this particular topic. I got a phone call yesterday from a member of the Advisory Council from my health centers down in the South Patchogue Center about our flu vaccines and that we're out of vaccines at the health centers. Is that true or have we been able to get -- I know this was coming, I think, a couple of weeks late, so maybe we've gotten that taken care of. Could you just tell me real quick?

COMMISSIONER TOMARKEN:
We were very low -- first of all, let me go back. There are five different products that we stock for different age groups. Mid-January, early January, we were low in the adult vaccine. We weren't completely out, but we were very low. In the next two weeks we received 6,430 doses. We have subsequently received more. We now have all the health centers stocked and we have 3700 vaccines in our inventory if needed.

LEG. CALARCO:
Great. Thank you.

CHAIRMAN SPENCER:
Thank you, gentleman. With that, it transitions to another important part of this conversation, which is our second presentation. I was thoroughly impressed, last year we had a program which is the HealthSmart Program, and we had to make some difficult decisions and, you know, that was one of the programs that was cut and I understand the conditions, but in light of the current circumstance I did want to follow-up with regards to HealthSmart. I learned that out of our 72 school districts that without funding the HealthSmart continues in 50 of our school districts, and that's because of the fine training that has been done and teachers that exist. But as time continues, without updating the material and as teachers retire, those services will gradually start to disappear. But we looked at our treatment services and what I've discovered is that HealthSmart is a major part of the preventive side of the equation.

So with us today we have two of our health services members in the Department of Health education, Nancy Hemendinger is here. You're by yourself today, okay. Nancy is here and I've asked her to come and to present to us the HealthSmart Program, but specifically the presentation she gave was showing how it tied into mental health hygiene and preventative services. So her presentation, which I saw, was fantastic and I asked if she could come and give that for us today.

MS. HEMENDINGER:
Well, first thank you for inviting -- I'd better sit down because I move a lot. First, thank you very much for inviting me to be able to talk about something I am so passionate about, and that is prevention. I wanted to give a little history. HealthSmart is a comprehensive K through 12th grade health education curriculum. We started to use and train teachers in HealthSmart back in 2001/2002 when our office had received the master settlement agreement money. It was done as part of a comprehensive best practices program that the Centers for Disease Control and Prevention recommended. That, yes, we should have adult cessation, yes, we need enforcement, and yes we need media, but we really need the prevention piece and that is in the schools. So we ended up with HealthSmart. Now, it's not ended up, we really did a lot of research.

We initially went out to the schools and surveyed and said what are your health education needs, and what we found, K through 6 there was some health education being done, but it really wasn't a consistent, comprehensive -- done in a comprehensive manner. On a secondary level, health certified health educators teach health education. K through 6 it's the classroom teacher, and they are not trained in health education. So we wanted to address K through 12, however, our emphasis has been on K through 6.

Now, what are the topics covered in HealthSmart. Tobacco use, use of alcohol and other drugs, physical inactivity, unhealthy dietary patterns, behaviors that result in unintentional and intentional injuries, behaviors that result in unintended pregnancy, STD, HIV and AIDS. Now, you can imagine when we have kindergarten, first grade teachers and we're telling them the State mandates you to teach HIV in kindergarten. They go pale because they can't believe they're going to have to teach HIV in a kindergarten class. And what that really means, then we get them to relax, is that that means handwashing. On an elementary level the handwashing is the foundation that we are building to keep germs out of your body. So coughing into the crevice of your arms, washing your hands. That's the foundation for HIV prevention. On a secondary level that's when we start to talk about abstinence and condom use as a germ barrier. So that's an example of how HealthSmart builds with one concept all the way through the grades.

Now, where do we get those topics from? Every two years the CDC administers something called the Youth Risk Behavior Survey. This is for 9th through 12th graders. How the CDC identified those topics was those answers in that survey, by the content in that survey. Those things that cause mortality and morbidity among our young people, that's what's in the HealthSmart curriculum, that's what CDC has identified needs to be addressed with our young people.

Now, at the Board of Health meeting you had asked a little bit or one of your colleagues asked a little bit about why HealthSmart. Well, there's another tool used when we talk about health education. It's called the Health Education Curriculum Analysis Tool called HECAT. What this does is it's developed by the CDC again to provide guidance to improve comprehensive health education, the selection and development. It provides the guidelines for best practices and also the guidelines to make sure curriculum meets the national health education standards. HealthSmart meets those standards. In addition, it meets the New York State Health Education standards.

HealthSmart, how is it different than other health education curriculums or the health education textbook that we used to see in schools? Well, HealthSmart is based on the theory of planned behavior. Now, what does that mean? Well, we know back in early 90s there were a lot more people smoking. They stopped smoking not just because we were telling them it's bad for you, they stopped smoking because we changed the culture, we changed the environment. And when we did that we put high personal value on the behavior, we changed the norm, and now we have a different culture around tobacco.

This is how HealthSmart works in the classroom. We want children to drink more water? Well, then we have a lesson about drinking water or handwashing. It becomes the norm in the classroom, and it becomes the norm in the school, and it also becomes the norm outside of school through the parents, and I'll talk about the parent component in a moment.

HealthSmart builds, and I'll show you lessons from mental health lessons from K through 12 in a moment. Each year -- of course we're going to start with a very simple concept in kindergarten, handwashing versus condom use or abstinence, and it builds each year as we go along. Curriculum is broken down with K through fourth grade looking like over in the corner you see the little yellow box. Then 5th and 6th grade is configured a little differently. They have magazines that they use and transparencies, and then the middle school and high school are also different. They have workbooks and they have additional units.

These are the -- what K through 4 HealthSmart curriculum look like. We have Blackline Masters, which I was asked at the Board of Health what that is. Those are the handouts that the teachers use, the assessment pieces, teacher's guides, posters, flip charts, program foundation and teacher background. Now, I have to say, when the teachers walk through the door they're not happy about being there. We do a lot of prep work even before they come to a training, because they have a lot on their plate. However, by the time they walk out of the door they're like, "We can do this". If they teach a 30 minute lesson from HealthSmart each week they will be meeting the New York State Health Education Standards and they will be going through the whole curriculum.

One of the things that the teachers love is on the back of the flip chart, and I can show you that later, is the lesson plan. So the prep time for them is very easy, it's very short as far as time goes. This is an example of what a lesson looks like. Very simply, this is a glass of water, how do we use water, the importance for the body, how much water is our body made up of, show us two-thirds, etcetera. Very, very simple. Of course, this is an elementary 1st grade level lesson.
This is what the 5th and 6th grade curriculum looks like, and you'll notice a CD that appeared. This CD can be used for the whiteboards instead of the transparencies because that was an older piece, and I will address the question also, the Board of Health, about updates to this curriculum in a moment.

My HealthSmart website, this provides updates. Now, all the years we have been training the teachers, especially K through 4th grade, they've been saying, "Well, why don't we get a CD or a flash drive" or "Why don't we have access so we can put all these materials additionally on our whiteboards." And we're saying, "It's coming, it's coming." Well, it's available, and I have to say ETR just contacted me last week and said any teachers that we have trained in Suffolk County, which is over 2500, they will be able to have access to updates for this curriculum and updates that they can use on their new technology.

One of the ways that I plan on using it is at the end of each year we do a year-end survey, because we want to make sure this investment is being used. So we do year-end survey and teachers send back how much of the curriculum they're getting through. Well, this year I'm going to put out the survey, and as I get surveys in I will give them access to the portal so they can use the updated materials.
Parent component. That was another thing that the CDC said you needed in a best practice. Besides training teachers, not just handing them a curriculum, parent component. Each unit in the HealthSmart curriculum has a family letter that goes over where their child is cognitively. How does a five year old think, how is your eight year old thinking? How are they taking in the culture around them? How do they deal with the concepts they will be learning in health education? And to continue that dialogue with the parents, there are parent take home pieces. And what teachers tell us they do is they send these materials home, have the parents sign-off on them, and then the children bring them back. That's an assessment tool used.

You can see here some of the subject topics, My Special Body, talking about body image, Troublesome Feelings, Table Talk, Families on TV. Are the families shown on TV real and honest? And this is when you can start to talk about what the kids are playing on those games, the violence on the games, what they're seeing in our culture on the TV. What is real, and what is really important as far as being a person, being a friend, being a family member, as opposed to what they're seeing.

Now, the American Psychological Association defines mental health as feeling good about yourself, feeling good about your relationship with others and being able to cope with life's changes. This is directly out of the HealthSmart secondary curriculum.

So how does the HealthSmart curriculum develop skills for good emotional health. Lessons, as I said, starting in kindergarten and going up, sharing feelings, building self-esteem, positive body

image, accessing help, coping skills, setting goals and taking action to achieve them.

So what I did was I pulled mental health lessons, a brief snippet from each grade. And so what does this have to do with gun control. Well, we were talking about mental health and the connection or the non-connection. But as you go through -- as we go through these lessons, think in terms of bullying prevention, think in terms of coping, think in terms of communication and other types of mental illnesses that go along with how these lessons are giving this student protective factors.

So in kindergarten, these are actual posters from the curriculum. They talk about identifying and understanding feelings; knowing my body, understanding their bodies and also, very importantly, having people, identifying safe people to go to who they trust when they have a problem, something about their body, something about their emotions that they don't understand. So learning how to communicate.

Now, the 1st grade lesson, now we go into well, how do I communicate, what do these words mean. And you'll notice there are nine words listed here. Remember that number, nine. And talking about having all kinds of feelings and learning how to communicate those feelings. You can't communicate feelings unless you understand what feelings are and what you're having, what they mean and how they feel.

In 2nd grade, and this is actually, because we do classroom visits, we took a picture of a classroom doing this lesson, a teacher in Suffolk County. Getting help with troublesome feelings. So again, that thing about accessing help. And then how do I express those feelings. I am feeling nervous because I'm presenting in front of the Health Committee. Not really, because I love talking about prevention, but that is, again, giving the young people, the children, the knowledge, the verbiage how to communicate their feelings. Remember that lesson also. And then continuing in the Personal and Family Health Unit, how their bodies change, how their feelings change as they're getting older.

Third grade. Am I safe, am I okay. If not, what must I do to be okay? Checking in with their feelings again, checking in with their bodies again. Predicting the future, because as a third grader now their world is expanding. It's not just their parents, it's not just that little classroom.

And then we go into 4th grade. Signals for personal support. Common theme, my thoughts, my feelings, my actions. You may have thoughts and feelings, but they don't always -- you have two actions you can take; one that will be healthy and one that may not be healthy. And then gaining the personal support when you are struggling with some type of feeling that you don't understand. Also in 4th grade, managing stress, coping strategies, going for help if you need it. Fourth grade, managing conflicts. Here's the bullying prevention. Understanding peer pressure, developing assertiveness skills, developing communication skills for conflict resolution.

Continuing on the same theme in the 5th and 6th grade. Media's influence on violent behavior, self-image and sexuality. So this is addressing all through the HealthSmart Curriculum is media literacy, but it really gets into it beginning in the 5th and 6th grade. Also addressing the puberty and again, the feelings that go along with it. Our educators assist teachers, train them, give them extra training in teaching puberty lessons, especially the anatomical and the emotional aspect. And what our contract health educators say is they have seen an increase in the children dialoguing about feeling bullied and feeling uncomfortable with their bodies, so we are responding to that need with additional programming.

Secondary school. That means middle and high school. These are taught by certified health education teachers. They add units. One is called Improving Health Behaviors, because now it's not just prevention, it's intervention, because we know by middle school/high school some of them on

that road of choices have taken a choice of maybe not so healthy behavior. Identifying what that behavior is and then getting the steps to change that behavior. For example, January first came, and I'm sure there are many people who decided I'm going to improve my dietary pattern or I'm going to improve my physical activity. There were things you did, you had an intention and there were things you did in that behavioral change, stages of change, to have success in that change. Secondary school has additional sections, abstinence and sexual health, emotional and mental health, HIV, STI and pregnancy prevention.

So all along I was giving you lessons about emotional and mental health, now we're in secondary school when things are really getting intense, and they're more on their own. So now they have specific units that deal with emotional and mental health, and these units address characteristics of good mental health, expressing emotions, effective communication, building healthy relationships and recognizing and managing stress.

Now, if you think back to those original lessons on a primary level, we have emotions of words. On a primary level there were nine emotions that the elementary students were working with. Same lesson on a high school level, but of course there are columns and columns because this curriculum builds. On the other side, I would feel. I would feel nervous because I'm presenting in front of the Health Committee today. Again, same concept over and over. We don't want just the knowledge, we want the behavior, the skills. We want the norm to change.

Additionally, specific topics are addressed across different units. For example, how to help a friend who has an eating disorder, mental health. It's in a nutrition piece, but it's a mental health issue. So we're also getting high school kids the ability to help their friends, to report when their friends may need help.

I was also asked at the Board of Health to talk a little bit about the violence and injury prevention components, which I'm not going to take you through each one, but I did want to point out that in the violence and injury prevention, I just hit three; managing interpersonal conflicts in nonviolent ways, managing emotional distress in nonviolent ways, get help to prevent or stop violence. Same concepts go across different units in the Health Smart curriculum. So when somebody says we need to talk about heroin use, for example. Well it is addressed because it's addressed on a kindergarten level, because we're giving basic concepts and those concepts build until you get into a high school level.

Now, the next piece -- that's HealthSmart. The next piece I'm going to show you I did show the Board of Health. This is a training component that our office put together, and the reason we put it together, again, is in response to what we were hearing from the students, how they are feeling bombarded, how they're not feeling good about themselves. We use this at the end of the HealthSmart training and the effect it has on the teachers is they get to feel how the kids feel every day in this culture.

CHAIRMAN SPENCER:
This is very good. We watched this. This would kind of let you see what it's like to be in a teenager's mind in this day and age with all of the visual input. So, take a look at this.

(Video Presentation)

So this is a training piece that we used at the end, actually, of the training, and the reason we put it at the end, and we asked the teachers how do you feel when you watch this, and they're like, "My gosh", it gives them a better idea of what the students they're teaching are facing. And they also feel like this is coming at them very quickly. We purposely put it together that way, but it's interesting; if I show it to high school kids, this is very slow for them because of the technology that

they're growing up with.

I just want to say also that where we are with HealthSmart, we were able to continue because I had some curriculum leftover. We were in the middle of training two -- in the middle of training two districts, Babylon Village and Copiague, when things got cut off. I did not have enough curriculum for K and 1 grades, but ETR, the publisher of HealthSmart, donated the curriculum I needed in July, and the County now recently accepted that donation. So I have scheduled training to at least honor that commitment.

HealthSmart won't end because we have spent 12 years building a foundation of teachers who think health education is important. People in my office, and myself included, we will continue to push the materials and make sure to provide technical assistance to those teachers we have already trained. Going forward I think -- you know, prevention to me is the most important thing.

I will share -- I want to thank you for addressing mental health -- two things. One, my daughter suffered with anorexia nervosa for eight years and so I understand the stigma, and that's why I'm sharing it, because I don't have stigma about that, but I think it's something that we're also seeing in the schools. And then another mental health issue, last week I buried my 23 year old niece as a result of a heroin overdose. And so bringing this to the table now, for me personally is so timely. I will do anything that Dr. Tomarken wants me to do to continue with our prevention efforts and I will also support anything the Health Committee or the County Executive would like us to do, and I know everybody in our office feels the same way, so thank you.

CHAIRMAN SPENCER:
Nancy, my heartfelt condolences with your niece, and you hadn't gone through this when you gave this presentation and it was as compelling. And, you know, I think that, you know, my fellow Legislators do appreciate how important this is and this is something that we have to protect, and we can do it working with the Executive's Office. This is something that we can probably do with, you know, minimal funding, but we have the heart and -- but we see the need is there. I have never been so profoundly infected -- affected in my entire career as I was by the Sandy Hook tragedy which is -- I appreciate all the presentations today. So thank you and I think we get it. Are there any questions from the Legislators? No. Nancy, thank you very much.

MS. HEMENDINGER:
You're welcome.

CHAIRMAN SPENCER:
So we'll be working with you and the Department of Health to see how we can support you moving forward from our perspective. And the presentation was fantastic.

LEG. MONTANO:
We do have a question.

CHAIRMAN SPENCER:
We do. I'm sorry.

LEG. MONTANO:
Hi, Nancy. I just wanted to -- could you just briefly address the funding issue? Were you defunded in part or were you completely refunded? Just talk to me about that.

MS. HEMENDINGER:
The school based component, we used to have a contract with BOCES. We had a certain amount of money that we paid them to assist us with this and they actually did the purchasing of the curriculum and there were other components, we had youth empowerment conferences, peer

education trainings for youth, which are also very important. We can't do the youth empowerment conferences, but we are doing the continuing peer education trainings.

LEG. MONTANO:
So just so I'm clear, this is money that was within the Health Department budget that you were using to contract with BOCES.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
Let's go back to this present budget. Is the budget amount that was appropriated for this particular activity the same as the year before? Is it more? Is it less?

CHAIRMAN SPENCER:
It's gone.

LEG. MONTANO:
It's gone completely?

CHAIRMAN SPENCER:
There is no funding. It's gone.

LEG. MONTANO:
How much money are we talking about here?

CHAIRMAN SPENCER:
Five-hundred and sixty thousand, approximately.

MS. HEMENDINGER:
It was the whole contract, but again --

LEG. MONTANO:
When was that wiped out, in this proposed -- this new proposed budget?

MS. HEMENDINGER:
That was last -- well, you can.

MR. FREAS:
It was -- what had happened.
LEG. MONTANO:
And you'll forgive me, I have not been on this committee, so this -- a little bit is new to me.

MR. FREAS:
What happened was that the contract had ended at the end of 2011 and BOCES had continued to do the work. They were warned that, you know, you guys don't have a contract, we really need to talk and come up with what we're doing.

LEG. MONTANO:
So it ended fiscal year 2011.

MR. FREAS:
It ended 2011.

LEG. MONTANO:
All right. December 31st fiscal year?

MR. FREAS:
Correct, the BOCES portion. There were also some -- there was one layoff in 4501, which is Health Education, and there was -- I think that the -- hold on a second.

LEG. MONTANO:
Well, educate me. Was this County money or was this pass through money or --

MR. FREAS:
County money.

LEG. MONTANO:
All right. So this was a totally funded County endeavor and the funding ended December 31st, 2011. BOCES continued to run the program without a contract; is that what you're saying? Yes? No? I don't know?

MR. FREAS:
BOCES continued to run the program. There was funding adopted in 2012 as part of the austerity measures that we passed in the spring, early summer of 2012. The funds for HealthSmart, in addition to the layoff, that -- the one layoff that was suffered in the Health Education Unit, the HealthSmart funds were removed from the line.

LEG. MONTANO:
In 2000 --

MR. FREAS:
Twelve.

LEG. MONTANO:
In 2000 -- let me do this my way. In 2012 there was no appropriation; am I correct? Yes or no.

MR. FREAS:
You are incorrect.

LEG. MONTANO:
I'm incorrect. There wasn't appropriation. How much -- when we passed the budget in 2011 for 2012, was there an appropriation?

MR. FREAS:
Yes.
LEG. MONTANO:
How much was the appropriation for?

MR. FREAS:
There was an appropriation for $576,000 at that time. We amended the budget -- we amended the 2012 budget in 2012, and that funding was taken out of the line. The contract had ended anyway, we still didn't have a contract and the decision was made not to continue with the program.

LEG. MONTANO:
Right, I got that. But then they continued to work, but we cut the program. So I assume that we reimbursed them. Yes? No?

MS. HEMENDINGER:
No. And I just have to -- the Health Department runs the program. It was a Health Department program. The people that worked on the whole school based program worked under us and we worked together on this program. So when that contract was not signed in the spring, we continued with the resources that we had -- because when you're doing trainings you order materials ahead of time of course for schools.

LEG. MONTANO:
Right.

MS. HEMENDINGER:
So I was able to continue with a few of the other Health Education staff left over to --

LEG. MONTANO:
Now, this Health Education staff came from the Department of Health?

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
They were County employees.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
The BOCES component, I assume that, maybe incorrectly, but I assume that they made expenditures or incurred costs for this program?

MS. HEMENDINGER:
They had bought the curriculum in 2011 for 2012, because that's --

LEG. MONTANO:
Did we reimburse them for that.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
Okay, so they've been made whole.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
All right. Now where are you at?

MS. HEMENDINGER:
Where we're at is, as I said, we had leftover curriculum. I'm honoring the commitments to the two school districts we had started, Copiague and Babylon village, and I will continue to visit schools. I will continue through our IT -- our IT Department as opposed to the BOCES, administer the year-end survey. The thing that we will not be able to do is once I run out of the curriculum, which once I finish these two trainings we'll be done with it --

LEG. MONTANO:
Okay.

MS. HEMENDINGER:
-- is to train additional schools, or if there's turnover, somebody retires, that person will be able to be trained. You will still have the kit in the classroom. And the positive is that ETR -- the people who are the publishers, will let schools who we've trained, the teachers we've trained, get on to the website so that they can get the updates that they need, which is a real positive for us in Suffolk County, because then our teachers will continue to be updated. We will continue to do what we need to do, even if it's just a few of us with limited funds.

LEG. MONTANO:
How much -- if the program was operating at a $500,000 budget; am I correct in that?

MS. HEMENDINGER:
Uh-huh.

LEG. MONTANO:
How much are you operating under at the present time?

MS. HEMENDINGER:
Well, that would probably -- my salary is -- this is probably about 40% of my time, and we have a contract educator that has been assisting me with the trainings.

LEG. MONTANO:
Is he an outside contract?

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
And what is that amount?

MS. HEMENDINGER:
They're about 300 maybe a month for the trainings.

LEG. MONTANO:
All right, so we're really talking nickels and dimes on that.

MS. HEMENDINGER:
Yes. Contract educators make $20 an hour.

LEG. MONTANO:
Okay. So I just want to do the math. So you were at 500,000 and now you're at really --

MS. HEMENDINGER:
Zero.

LEG. MONTANO:
Zero, and you're just kind of filling in the gaps in between your other assignments.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
And that's the extent of the program.

MS. HEMENDINGER:
Yes.

LEG. MONTANO:
And this occurred in 2012. And in 2013 where are you at?

MS. HEMENDINGER:
I will continue to visit schools, reach out to schools, find out what else they need, administer that year-end survey, and once I get those results back I will let them know about the updates. We, of course, have other presentations. We have educators that are constantly going into schools doing HIV education, STI, eating disorder prevention, body image, tobacco control. Those are all push in, but push in presentations are standalone -- will be standalone if they don't have HealthSmart. HealthSmart with the push ins are like booster lessons and that's why the whole picture, the whole comprehensive initiative, was really working for Suffolk County. We're a model program. I was asked to speak on a national level about the program in Suffolk County. We've had requests -- New York City followed suit with HealthSmart curriculum. They were involved with it because of us.

LEG. MONTANO:
Uh-huh.

MS. HEMENDINGER:
So we were the leaders in this area of comprehensive health education and having the Health Department help schools get to that point.

LEG. MONTANO:
And now you're out of it is what you're saying.

MS. HEMENDINGER:
Out of it as far as moving forward, but we will hold on to the investment. I call it an investment of 12 years because the curriculum is still in the classroom, but as you know, human nature, they need to continue to hear about it. So as long as the Office of Health Education exists, our health educators, including myself, will remind them we trained you, how's it going, what else do you need. Not that we can purchase anything, but we certainly can advocate with them.

LEG. MONTANO:
That sounds good and noble, I just don't understand how you run a $500,000 program without $500,000; could you explain that to me?

MS. HEMENDINGER:
Well, I've taken on the coordination piece for this program as far as coordinating the training, keeping track of the schools, and that's what the BOCES person did. So I don't just work seven hours a day. I work because I believe in what I'm doing. No, the County doesn't pay me overtime.

LEG. MONTANO:
Yeah, I was going to ask you that, too.

MS. HEMENDINGER:
No, no, no.

LEG. MONTANO:
No, I understand your commitment. I'm just looking at it from the reality of the monetary situation. And what you are telling me sounds good but, you know, my profession outside of the Legislature is being a lawyer, and I can't run an office without money. I've got to pay bills, I've got secretaries, I got phones. So I'm trying to figure out how you are running a $500,000 program with no money irrespective of your good intentions and your commitment to the concept.

MS. HEMENDINGER:
We're not as expansive as we used to be. The youth empowerment conferences have been cut. The peer education trainings, instead of doing four a year, we'll do two a year. Will I be reaching all 51 school districts by myself? It's impossible.

LEG. MONTANO:
No, that's my point. Okay. I really appreciate it. It's been very informative and I'm glad we had this brief chat.

CHAIRMAN SPENCER:
The other thing that's important, too, is within the school districts, and I'm going to ask if you would do the same, the school districts all have PTA councils that have taken this up, and so they're working with the Health Department. My wife is chair of one of them in my district, and what they're doing is they're perpetuating the HealthSmart Program with volunteers and moms and working with those teachers. But the real danger comes when the last trained teacher in a district retires, then the program dies.

So what I'm going to ask them to do, and what we've been working with them is to -- this has to stay alive. This is that piece of the puzzle. If you look at preventive education for 1.5 million people, the half a million dollars doesn't provide in-patient services for ten people for two weeks. So you imagine, even if you catch less than .1% of the kids that go through the HealthSmart Program, this is where you can't see the impact of the budget in dollars because it's not felt, but kids getting that education and getting the preventive services, if they don't go on to have -- need in-patient treatment, we're saving tons of money right there. Do you have a --

MR. FREAS:
Legislator Montano, could --

LEG. MONTANO:
I'm not sure I got that, but I don't want to delay it. I'm satisfied with the answers that I've gotten today. Did you want to add something to the point?

MR. FREAS:
I did.

LEG. MONTANO:
Go ahead.

MR. FREAS:
As I just said to Nancy, when we were looking at this last year I knew the way the contract broke down off the top of my head, and I don't have those notes, they're in hard copy at my desk. But generally speaking, the curriculum purchased on an annual basis was about $200,000 a year. The remainder of that five-hundred some odd dollars --
LEG. MONTANO:
Is that for copyright reasons or something?

MR. FREAS:

Correct.

LEG. MONTANO:
Okay.

MR. FREAS:
Correct. We have run into similar problems when we've looked at health literacy tools for the health center.

LEG. MONTANO:
Right. So you can't use -- you can't use the old program unless you pay the additional copyright expenses for this year; is that accurate?

MR. FREAS:
You could, as long as you had the appropriate licenses, so to speak, the appropriate amount of licenses you could, and once you get beyond that to go to a new district and train 50 educators, you would need to have -- if you only had ten --

MS. HEMENDINGER:
Curricula.

MR. FREAS:
Curricula left, you'd need 40 more licenses. That's basically the way. It's the way ETR makes money.

LEG. MONTANO:
All right. So for each school you got to buy a different -- you got to pay a different fee for every school. Is that what you're telling me?

MS. HEMENDINGER:
Each -- we need curriculum for each teacher and the reason --

LEG. MONTANO:
Right, and you got to pay for that.

MS. HEMENDINGER:
Yes.

MR. FREAS:
Yes.

LEG. MONTANO:
That's my point.

MS. HEMENDINGER:
That's what the County paid -- that's what we paid for.

LEG. MONTANO:
Right, and that's what you're not paying for now.

MR. FREAS:
Correct. We're not paying for that --
LEG. MONTANO:
Because you don't have any money for it.

MR. FREAS:
Right. We're not paying for that and we're not paying for the BOCES contract to manage the program. Now, the management function's been taken over mostly by Nancy, but because the program is also substantially scaled down, because we don't have any --

LEG. MONTANO:
Right. But what I'm hearing is, in all due bluntness, what I'm hearing is that the program is basically defunct because you don't have any money, other than your commitment, which I applaud and I understand your desire to continue the program. I'm just am baffled by how you continue a program if you don't have dinero, you don't cash. I mean, do you have an answer for that?

MS. HEMENDINGER:
When I went to school for health education and prevention they told us, "Don't expect to have a lot of money."

LEG. MONTANO:
You're not going to get rich, I got you.

MS. HEMENDINGER:
Right. And so when we had the master settlement agreement back in 2001 for our office, it was probably just miraculous as far as my career. Thirty years I've worked for the Health Department, and that time span, and that's why I am as hopeful as I am. We have a foundation, so we have an investment. I don't feel hopeless. Certainly if there is money available to continue at the level or even partly at an increased level I would love that, but that comes down to the Commissioner, that comes down to the resources in the County.

LEG. MONTANO:
I understand. Thank you very much. I appreciate it.

CHAIRMAN SPENCER:
Legislator Hahn.

LEG. HAHN:
Just remind me, because maybe I'm wrong. Isn't this also what replaced DARE?

LEG. CALARCO:
It is.

LEG. BROWNING:
Yes.

MS. HEMENDINGER:
Yes. The County Executive at the time when -- because DARE was not shown to be evidence based or researched based and we wanted something -- and it wasn't comprehensive, it was for maybe one or two grades, so that limits it. And so the County Executive at the time -- yes, and this took over the DARE Program. We were already in the schools but --

LEG. HAHN:
Right.

MS. HEMENDINGER:
Right.

CHAIRMAN SPENCER:
All right. We're going to move on to our agenda. Thank you very much, Nancy. That was excellent and we will follow-up with you.

Tabled Resolutions

First is IR 1920 from our Tabled Resolutions. ***IR 1920-2012, Establishing "The Truth About Energy Drinks" public education campaign to increase awareness of side effects associated with energy drink consumption (Spencer).*** I'm going to make the motion to table. We're working on this educational program.

LEG. BROWNING:
Second.

CHAIRMAN SPENCER:
Second. All those in favor? Opposed? Abstention? Motion is tabled. ***(Vote: 5-0-0-0)***

IR 1929-2012, Adopting Local Law No. -2013, A Local Law to strengthen requirements for safe disposal of expired and unused medications (Hahn).

For the purpose of discussion motion to approve or table?

LEG. HAHN:
I want you to table but I --

LEG. CALARCO:
I'll make a motion to table.

LEG. BROWNING:
I'll second that.

CHAIRMAN SPENCER:
All right. Motion is -- there's a motion and a second to table. On the motion, Legislator Hahn has a question for Dr. Tomarken.

LEG. HAHN:
So I just wanted to understand. We now have complete compliance in terms of everybody who is supposed to submit their plans for disposing?

COMMISSIONER TOMARKEN:
For this year we have 97%. There are two out of 64 that have yet to submit, but we're in contact with them.

LEG. HAHN:
This year as in 13?

COMMISSIONER TOMARKEN:
Yes. At the end of the month is the deadline.

LEG. HAHN:
The end of the month is the deadline, okay. So it's still possible that they'll meet that.

COMMISSIONER TOMARKEN:
We're in touch with them.

LEG. HAHN:
Do you have any feeling like there's further action needed on this? Because I was getting the sense that there might not be.

COMMISSIONER TOMARKEN:
We had 100% last year, we're at 97. I think I did mention some reservations about something that had no flexibility for an institution that might have some difficulties beyond their control in submitting it, but by and large we've had good cooperation.

LEG. HAHN:
And what are we doing with the plans now?

COMMISSIONER TOMARKEN:
Well, the requirement is that they submit a plan and we look at the plan, and if we think it's appropriate, we're okay with it. If we think there's problems with it we go back and talk with them and have them modify it.

LEG. HAHN:
So how often do you ask hospitals or nursing homes to modify their plans?

COMMISSIONER TOMARKEN:
I would say roughly --

MS. ORTIZ:
You don't have to hold it anymore. It stays on.

COMMISSIONER TOMARKEN:
Sorry. I'd say roughly about 10%.

LEG. HAHN:
I would -- is there any -- are you tracking kind of what people are doing and where the problem areas are? Because I would like to, you know, work with Doc and others on, you know, the pharmaceutical in our water is an issue, and I want to kind of get a sense in how we can -- is there any way to review these plans and think about it together from an environmental perspective?

COMMISSIONER TOMARKEN:
We can share them with you if you'd like to see them. We can PDF them to you.

LEG. HAHN:
Okay. Thank you very much.

DR. TOMARKEN:
Okay.

CHAIRMAN SPENCER:
So we have a motion to table and a second. All those in favor? Opposed? Abstentions? Motion is tabled. ***(Vote: 5-0-0-0)***

Introductory Resolutions

IR 2230-2012, Adopting Local Law No. -2012, A Local Law to amend the membership of the Suffolk County Disabilities Advisory Board (Cilmi).

Motion to table for a public hearing. Second on the motion? Second by Legislator Kennedy. All

those in favor? Opposed? Abstentions? Tabled. ***(Vote: 5-0-0-0)***

We have no other business before us today. Motion to adjourn.
Thank you.

(*The meeting was adjourned at 4:14 P.M.*)